I thought they might perhaps have been preceded by a papular urticaria, possibly with vesicles. The second time I saw her she had linear bullæ along the sides of the fingers, as well as the round lesions, the scars of which can be seen now. I believe this is an entirely artificially produced eruption; my diagnosis is not supported, of course, by the mother.

Chronic Relapsing Pemphigus or Dermatitis Herpetiformis in an Old Man with Chronic Lymphocytosis.

By F. PARKES WEBER, M.D.

THE patient, J. G., aged 70¾, German (no Hebrew ancestry), enjoyed good health till four years ago, when the present illness commenced. At first there were only a few isolated bullæ, the formation of which was preceded by local itching and scratching. Since then he has suffered on and off, more or less, from a bullous eruption, with decided exacerbations from time to time. At present, during one of these exacerbations, the bullæ are scattered all over the body and limbs, with the exception of the palms of the hands and the soles of the feet, which have always remained free. The mucous membranes are not affected, though he says that he has occasionally had a few lesions in the mouth. There is no special grouping of the lesions. Local itching mostly precedes the onset of the bullæ, and he says that this itching has sometimes been terrible. According to the patient the bullæ develop on previously normal-looking skin, and this seems to be the case, though there are erythematous spots and patches to be seen, which apparently mark the site of former bullæ.

By ordinary examination of the patient, who is not emaciated and mentally is apparently healthy, nothing abnormal has been found in the thoracic and abdominal viscera, the urine, the eyes, and the nervous system. The spleen and liver are not enlarged, but, owing to the chronic cutaneous trouble, there is moderate enlargement of the superficial lymph-glands (cervical, axillary, inguinal and supracondylar). There is no fever. The gastric contents after a test-breakfast (February 8, 1927) showed no free hydrochloric acid, but the examination was not complete. Brachial blood-pressure; systolic, 120 mm. Hg; diastolic, 65 mm. Hg. The Wassermann reaction is uncertain, owing to "Eigenhemmung." (The blood-serum is not clear, even during the fasting state.) The blood-sugar (fasting) is 0·100 per cent.

The fresh cutaneous bullæ contain very few cells, but most of the cells are eosinophils. A recent blood-count gives 4,288,000 red cells and 37,600 white cells to the c.mm. of blood; a differential count of white cells, from blood obtained with a syringe from a vein, gives: polymorphonuclear neutrophils, 26·3 per cent.; lymphocytes, 68·0 per cent.; monocytes, 2·0 per cent.; basophils, 0·7 per cent.; eosinophils, 3·0 per cent.

This marked lymphocytosis is chronic, for a differential count taken by Dr. F. E. Loewy on August 16, 1925, gave: polymorphonuclear neutrophils, 22·0 per cent.; lymphocytes, 68·6 per cent.; monocytes, 4·7 per cent.; no basophils; eosinophils, 4·7 per cent. The chronic lymphocytosis in this case is very interesting, and it may be compared to that found by Sequeira and Panton in cases of what they termed "lymphoblastic erythrodermia" (*Brit. Journ. Derm. and Syph.*, London, 1921, xxxiii, 391-400).

Another elderly man, L. J., aged 69, who for several years on and off has suffered from similar chronic recurrent pemphigus or dermatitis herpetiformis, has occasionally been an in-patient at the German Hospital, and I have just heard (through the kindness of my colleague, Dr. E. Schwarz) that he is at present quite free from bullæ.

Dr. A. M. H. GRAY said he thought this case belonged rather to the "dermatitis herpetiformis" group, as at present there were erythematous lesions on the body, apart from bullæ. He agreed with Dr. Graham Little, however, as to the practical impossibility of differentiating these cases; and this view was strongly held in America. Some authorities said that the conditions could not be distinguished until the patient had died.

With regard to analysis of the stomach contents, the mere determination of absence of hydrochloric acid, without employing a fractional test-meal, was not of much value unless a fractional test-meal had been given. He asked whether the total chlorides in this case were known. Dr. Bolton had clearly shown that the acidity of the stomach depended largely on the amount of regurgitation from the duodenum.

Postscript (March 28, 1927): The patient, J. G., suddenly developed severe facial erysipelas on March 18, which spread rapidly over the body, and terminated fatally on March 20. He had recovered from an attack of erysipelas about two years previously. A post-mortem examination showed, by microscopic examination, extensive non-inflammatory, systematized, interacinous, lymphocytic infiltration of the liver, characteristic of chronic lymphatic leukæmia. The spleen was about six times the size and weight of a normal spleen, and microscopical examination showed that this was due largely to lymphocytic infiltration, and not merely to the acute fatal erysipelas. There was old, chronic thickening of the splenic capsule. The kidneys, by microscopic examination, showed scattered patches of lymphocytic infiltration. The chronic lymphocytosis and enlargement of the superficial lymph-glands observed during life were, therefore, certainly due to a condition of chronic lymphatic leukæmia. In fact, the supposed "lymphocytosis" was leukæmic and not a true lymphocytosis.—F. P. W.

Persistent Erythema, with Ischæmic Circulation in the Left Foot, possibly in part connected with Prolonged Use of a Plaster Bandage for Tuberculous Disease of the Left Knee.

By F. PARKES WEBER, M.D.

THE case has been described in the *Proceedings* of the Clinical Section Meeting of February 11, 1927.[1]

Dr. H. C. SEMON said he had been called in to treat a case in which peri-arterial sympathectomy had been performed for incipient gangrene, in an elderly man. His foot had been saved by the operation, but subsequently an intractable ulcer had developed in the region of the heel. He (Dr. Semon) thought that this had occurred as a result of the operation, and that care was necessary in deciding as to surgical treatment in these cases.

Ringworm of the Scalp in an Adult.

By H. MACCORMAC, C.B.E., M.D.

THE patient is a railway employee, aged 29. His occupation does not bring him into contact with horses, and it has not been possible to discover the source of his infection. The lesion, which is on the left side of the head, is stated to have developed abruptly four of five weeks ago, and now presents the appearances of a modified inflammatory ringworm of the scalp; the diagnosis has been confirmed by the discovery of a large-spored fungus in the hair.

[1] See *Proceedings*, 1927, xx (Clin. Sect.), 46.